2017-1063

PRINTED: 07/13/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012699	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL NORTH	916 PACIFIC AVE FI 7 EVERETT, WA 98201

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L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 WAC Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. Onsite dates: 6/27/2017 to 6/28/2017 Examination number: 2017-1063 The survey was conducted by: Tyler Henning, ScM, MHS, PHA Kimberly Metz, MSN, BSN, RN, who was in orientation at the time of survey. The Washington Fire Protection Bureau conducted the fire life safety insepction on 6/27/2017	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 7/30/2017. 4. Return the ORIGINAL REPORTS with the required signatures.	
L 345	322-035.1I POLICIES-PHARMACY WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (i) Pharmacy	L 345		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

CEO 1/25/17

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L 345	Continued From Page 1 and medication services consistent with WAC 246-322-210; This RULE: Is not met as evidenced by: Item #1 Safe Medication Administration .Based on observation, interview, and review of hospital policies and procedures, the hospital failed to ensure staff members followed policy and procedures for safe medication administration. Failure to follow safe medication administration procedures puts patients at risk of receiving the wrong medication or treatment resulting in patient harm and/or death. Reference: Institute for Safe Medication Practice (ISMP): Guidance on the Interdisciplinary Safe Use of Automated Dispensing Cabinets, 2008. ISMP Core Process #8 requires organizations develop procedures to ensure the accurate withdrawal of medications from the automatic dispensing cabinet (ADC) which include guidelines that: 1. Require that practitioners remove medications from the ADC one patient at a time. Findings included: 1. Review of the hospital's policy and procedure titled, "Medication Administration," Policy Number 28, Effective Date: 3/01/17, showed the medication administration procedure requires medications be prepared for one patient at a time. 2. On 6/27/2017 from 9:50 AM-10:15 AM, Surveyor #2 inspected the hospitals medication room. The observation showed three drinking cups containing unit dosed medications on the counter near the Pyxis® (an automatic dispensing	L 345		

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L 345	Continued From Page 2 cabinet). Each cup was labelled with a patient's first name and last initial (Patient #1, #2, and #3). 3. At the time of this observation, during an interview with the Registered Nurse (Staff Member C) and the Nurse Manger (Staff Member D), the Registered Nurse stated that it was the medication administration procedure to remove multiple patients' medications from the Pyxis® ahead of time and then scan the medications into the electronic medication record prior to individual patient medication administration. Staff Member C stated that the medications were pulled from the Pyxis® in advance because it took a long time to pull them individually and patients were lined up at the window waiting for their medications. The Nurse Manger (Staff Member D) verified this was the procedure. 4. On 6/27/17, at 1:00 PM, Surveyor #2 interviewed the hospital's Director of Pharmacy (Staff Member E) and the hospital's Pharmacist (Staff member F). During this interview, Staff Member E, stated it was "the standard of practice in behavioral health" to remove multiple patient medications from the Pyxis® prior to medication administration. The Pharmacist (Staff Member F) agreed this was the hospital's practice. Item #2 Medication Disposal Based on observation, interview, and review of hospital policies and procedures, the hospital failed to ensure staff members followed policy and procedures for disposal of medication after patient refusal to take medications. Failure to follow medications disposal procedures put patient at risk for receiving the wrong	L 345		

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L 345	Continued From Page 3 mediation resulting in patient harm and/or death. Findings included: 1. Review of the hospital's policy and procedure titled, "Medication Administration," Policy Number 28, Effective Date: 3/01/17, showed that medications are to be administered immediately after the medication is prepared without a break in process by the individual who prepares the dose and the expiration date and the dose of the medication must be verified prior to administration. The procedure for managing unused or unusable medication was to return intact (sealed) medications to the patients' supply or pharmacy per hospital policy and to destroy unusable mediations per hospital policy. 2. On 6/27/2017 at 9:50 AM to 10:15 AM, Surveyor #2 inspected the hospitals medication room. The observation showed a medication cup containing a white oval pill sitting on the top of the Pyxis® (an automatic dispensing cabinet). The cup was labelled with a first name, a date, and the medication name Benztropine (a psychiatric medication used to treat Bipolar Disorder). Surveyor #2 noted there was no medication dosage, no medication expiration date, or patient last name written on the medication cup. 3. At the time of this observation, during an interview with the Registered Nurse (Staff Member C), the Registered Nurse stated Patient #4 had refused the medication and she was going to try to administer it to him later. The Registered Nurse stated she had already scanned the medication *and removed it from its original packaging* before the patient refused. 4. On 6/27/2017 at 10:08 AM the Registered Nurse (Staff Member C) left the medication room	L 345		

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L 345	Continued From Page 4 to administer medication to a different patient leaving the medication cup containing the pill unattended on top of the Pyxis®. The Registered Nurse (Staff Member C) returned to the medication room 10:14 AM. 5. On 6/27/17 at 10:14 AM, Surveyor #2 interviewed the Nurse Manager (Staff Member D). During this interview the Nurse Manager verified the opened and improperly labelled medication should have been disposed of. The Registered Nurse (Staff Member C) disposed of the medication at the time of the interview.	L 345		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This RULE: is not met as evidenced by: Based on observations and policy and procedure review the hospital failed to ensure staff members followed the hospital policy for hand hygiene. Failure to perform hand hygiene after contact with potentially contaminated surfaces places patients and staff at risk of infection Reference: Centers for Disease Control and Prevention. Guideline for Hand Hygiene In Health-Care Settings: Recommendations of the	L 690		

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L 690	Continued From Page 5 Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16):[pg. 33]. "Recommendations: 1. Indications for handwashing or hand antisepsis. J. Decontaminate hands after removing gloves." Findings: 1. The hospital policy titled, "Hand Hygiene" (Policy #1600.4.4, Rev. 3/2017), states that staff should perform hand hygiene following exposure to potentially contaminated environmental surfaces. 2. On 6/27/2017 from 9:40 AM to 10:07 AM, Surveyor #1 observed a housekeeper (Staff Member A) cleaning the dining room of the facility. The staff member did not conduct hand hygiene following glove changes on five separate observations. 3. On 6/27/2017 from 10:17 AM to 10:35 AM, Surveyor #1 observed a housekeeper (Staff Member A) perform a patient room cleaning to ready it for a patient arrival. During the procedure, the housekeeper cleaned the mattress and removed her gloves before retrieving clean linens to make the bed. She did not perform hand hygiene prior to handling the clean linens and making the bed.	L 690		
L 715	322-100.1E INFECT CONTROL-PROVISIONS WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (f) Provisions for: (i) Providing consultation	L 715		

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L 715	Continued From Page 6 regarding patient care practices, equipment and supplies which may influence the risk of infection; (ii) Providing consultation regarding appropriate procedures and products for cleaning, disinfecting and sterilizing; (iii) Providing infection control information for orientation and in-service education for staff providing direct patient care; (iv) Making recommendations, consistent with federal, state, and local laws and rules, for methods of safe and sanitary disposal of: (A) Sewage; (B) Solid and liquid wastes; and (C) Infectious wastes including safe management of sharps; This RULE: is not met as evidenced by: .Based on observation and interview the hospital failed to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. Failure to maintain a sanitary environment put patients and staff at increased risk of exposure to infectious organisms. References: . APIC Guidelines for Infection Control Practice 4th Edition 2014 state, "supplies must be stored at least 8 inched off the floor ...removed from outside shipping cartons or corrugated cardboard before storage to prevent contamination with soil/debris that may be on cartons ... must ensure all objects and surfaces are decontaminated as a common strategy to reducing infection." Findings included: 1. On 6/27/2017 from 9:50 AM-10:15 AM,	L 715		

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L 715	Continued From Page 7 Surveyor #2 inspected the hospitals medication room. The observation showed a corrugated cardboard box containing a stock of drinking cups and a corrugated cardboard box containing 12 bottles of Gatorade drink sitting on the floor. 2. During this observation, Surveyor #2 observed a corrugated cardboard box containing eight drinking cups filled with patients' topical medications sitting on the counter. 3. At the time of this observation, the Nurse Manager (Staff Member D), confirmed these findings, removed the cardboard boxes off the floor, and replaced the cardboard box containing the patient medications with one that could be washed and sanitized.	L 715		
L 880	322-140.1i ROOM FURNISHINGS WAC 246-322-140 Patient living areas. The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (i) A bed for each patient at least thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow; This RULE: is not met as evidenced by: Based on observation and interview, the hospital failed to ensure that patients had an easily cleanable mattress. Failure to provide an easily cleanable mattress places patients at risk of infection.	L 880		

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L 880	Continued From Page 8 Findings: 1. On 6/27/2017 from 10:17 AM to 10:35 AM, Surveyor #1 observed a cleaning procedure in patient room 702. During the procedure, the surveyor observed a mattress with large tears measuring approximately 3 feet in length. The tears caused the foam in the mattress to be exposed, making the mattress uncleanable.. 2. A registered nurse (Staff Member B) confirmed the finding at the time of the observation and stated that the facility had placed a work order for new mattresses.	L 880		